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Joint Inspection Unit

Report of the Joint Inspection Unit on the review of the progress made by the United Nations system organizations in achieving Millennium Development Goal 6, Target 7, to combat HIV/AIDS

Note by the Secretary-General

The Secretary-General has the honour to transmit to the members of the General Assembly the report of the Joint Inspection Unit entitled "Review of the progress made by the United Nations system organizations in achieving Millennium Development Goal 6, Target 7, to combat HIV/AIDS" (JIU/REP/2007/12).

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REVIEW OF THE PROGRESS MADE BY THE UNITED NATIONS SYSTEM ORGANIZATIONS IN ACHIEVING MILLENNIUM DEVELOPMENT GOAL 6, TARGET 7, TO COMBAT HIV/AIDS

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EXECUTIVE SUMMARY

Review of the progress made by the United Nations system organizations in achieving the Millennium Development Goal 6 - target 7 - to combat HIV/AIDS
JIU/REP/2007/12

Objective: To assess the progress made in the achievement of Goal 6, target 7, to have halted by 2015 and begun to reverse the spread of HIV/AIDS, and to provide Member States with an objective assessment of the efficiency and effectiveness of the policies and programmes implemented and the bottlenecks in achieving this target.

Key issues, main findings and conclusions

- By the end of 2006, more than 25 million people had lost their lives to AIDS, and an estimated 39.5 million were living with HIV/AIDS. In 2006 alone, there were 4.3 million new infections and 2.9 million deaths due to AIDS. There is an upward trend in the prevalence of HIV infections since the adoption of the target. There has been an increase of approximately 28 per cent in the number of people living with HIV in 2006 as compared to the 2000 estimates. The future course of the disease and its real magnitude remain unknown.

- The most important factor that limits the effective functioning of the joint United Nations Programme on HIV/AIDS (UNAIDS) is its weak and outdated mandate. The Economic and Social Council established the mandate in 1994 when the pandemic was viewed as a health problem with limited impact. Thirteen years later, the situation has drastically changed. UNAIDS now has a broad, dynamic and challenging responsibility with greater accountability to its stakeholders. UNAIDS progress depends on actions taken by other entities/actors, such as national Governments, international donors and civil society over whom it has no institutional authority. The mandate of UNAIDS needs to be enhanced and reinforced. The authority of the UNAIDS secretariat needs to be enhanced for effective coordination.

- The existing partnership of ten Cosponsors is too many. Neither the UNAIDS secretariat nor the Programme Coordinating Board (PCB) has any controlling organizational authority over the Cosponsors. Consequently, little can be done to exert pressure on the Cosponsors to become effective partners within UNAIDS. There is a certain degree of overlapping and duplication of activities among the Cosponsors at the country level. Prevention of mother-to-child transmission, which is a major prevention activity, is a vivid example of such a duplication of efforts.

- Since its inception in July 1995, the UNAIDS PCB has held twenty meetings and has provided meaningful guidance and direction to UNAIDS. However, the effectiveness of the PCB is limited by several factors. In the existing institutional framework, the decisions of the PCB are not automatically binding on the Cosponsors. PCB decisions need to be endorsed by the governing bodies of all the Cosponsors before they can be implemented. This is a time-consuming process, which at times has a detrimental effect on issues that need to be acted upon immediately.

- The Committee of Cosponsoring Organizations has only limited authority. It is neither an executive nor a monitoring body and only endorses the budget and the workplan of UNAIDS. Moreover, it has authority only for activities financed from the UNAIDS Unified Budget and Workplan (UBW) and has no authority over the individual Cosponsors' programmes on HIV and AIDS.

- With regard to the division of labour, there is clearly a lack of awareness and clarity among the various stakeholders at the country level, particularly among the various

government departments and civil society partners on the division of labour and its modalities. The lead agency concept among the United Nations country teams also lacks clarity due to the overlapping mandate of the Cosponsors. There are overlapping issues in the division of labour, such as the prevention of mother-to-child transmission, women and children, youth and prevention efforts that have remained unresolved among the Cosponsors.

- Only limited progress has been made with regard to the joint programming as a result of the inability of country teams to allocate adequate time for developing joint programmes due to overlapping priorities, such as the United Nations Development Assistance Framework and country planning cycles, which provide the support for the joint programmes. The main challenges facing joint programming include the continued development of joint plans based on individual United Nations agency imperatives and priorities, rather than the development of integrated joint plans that are based on national needs and priorities.

- The application of the "three ones" principles is central to the coordination efforts at the country level. A key challenge for the effective implementation of the "three ones" principles at the country level is the existence of many coordination structures with overlap in membership and focus, often without linking consultation and decision-making structures and processes. The typical example of overlap is between the National AIDS Councils (NACs) and the country coordinating mechanisms (CCMs) of the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM).

- About 85 per cent of affected countries have national AIDS action frameworks or national strategic plans (NSPs). In order to be useful, NSPs have to be fully costed, with workplans translated into practical plans suitable for regional/grass roots implementation, and budgets that specify sources and allocation of funds. Many of the frameworks are not translated into workplans and budgets; it is estimated that only 60 per cent of the frameworks are costed and budgeted. Similarly, only 52 per cent have been translated into an operational plan and/or annual priority action plan. Many Member States have difficulty in translating national plans into actionable regional/grass root-level plans.

- The establishment and maintenance of a broad-based NAC, with the involvement of diverse stakeholders, is a political as well as a technical issue with its related problems. It would be too ambitious to create a completely new multi-sectoral mechanism and give it a remit to lead and coordinate the response of a wide range of well-established and powerful stakeholders. Often, the high-profile launching of an infant mechanism into a complex and highly politicized national AIDS response has caused tensions and frustrations among the various stakeholders, and in some cases has lost their support.

- A significant number of countries still do not have a funded, functioning monitoring and evaluation (M&E) system, which has been developed through partner coordination. Shortcomings in M&E systems represent one of the most pressing challenges standing in the way of achieving the target set by this Millennium Development Goal (MDG). The challenges include weak collaboration among stakeholders, shortage of M&E skills, insufficient financial and other resources for M&E, and the absence of well-functioning systems for collecting, analysing and reporting on the data needed for M&E.

- The "3 by 5" initiative has achieved only a limited amount. It was estimated that by December 2005, only 1.3 million people were under antiretroviral therapy or antiretroviral treatment (ART) as opposed to the targeted 3 million. The major achievement of the initiative was that it showed that with significant mobilization of resources and efforts from various stakeholders, antiretroviral therapy could be provided in even the most resource-constrained settings like, for example, in sub-Saharan Africa. However, the striking differences between regions in the percentage of ART coverage of the needy population

underscore the fact that many countries are far from containing their growing AIDS pandemic.

- Universal access to care and treatment for all those who are in need by 2010 is an ambitious goal that provides lifelong support. The scaling-up towards universal access should be equitable, accessible, affordable, comprehensive and sustainable. In other words, it faces many challenges. The national health systems in most of the affected Member States are increasingly facing an unprecedented challenge due to a lack of investment in health services and the rapid scale-up of ART. The national health systems that are delivering maternal and child health services are under enormous strain, catering for large numbers of people living with HIV in need of lifelong care for chronic disease.

- Inadequate numbers of health workers are a major constraint to the rapid scaling-up of ART programmes. The expansion in labour markets has intensified professional concentration in urban areas and migration within regions and from developing to developed countries. There is an exodus of skilled health workers from the public to the private sector due to attractive pay and working conditions. Most of the public health services suffer from low pay, poor occupational health and safety conditions, lack of training and prospects for career advancement, poorly supplied medical facilities, an acute shortage of staff, and poor management and overall health system governance.

- The scaling-up of ART has shifted the focus onto treatment and considerably weakened prevention efforts. The challenges posed by universal access to treatment are formidable and need resources. As a result, many of the civil society partners that were traditionally involved in community mobilization and prevention have shifted their focus to treatment support activities, resulting in greater reduction in the scaling-up of prevention activities. Furthermore, a major part of donor funding is earmarked for treatment and the affected Member States are not able to allocate a matching share of domestic funding to prevention efforts.

- The financial resources needed for HIV/AIDS show an increasing trend due to the increase in the numbers of people living with HIV and the expansion in HIV/AIDS programmes to serve more of those in need. The financial resources available for HIV/AIDS fall far short of what is needed to scale up towards universal access. UNAIDS estimates that the amount needed for an expanded response in low and middle income countries will be US$ 18.1 billion in 2007, US$ 22.1 billion in 2008 and US$ 30.2 billion in 2009. Against this, the money received, the existing pledges, commitments and trends indicate that the available funds are US$ 10 billion for 2007, i.e. a resource gap of US$ 8 billion in 2007. To meet the goal of universal access by 2010, available financial resources for HIV must quadruple by 2010 compared to 2007 – up to US$ 42.2 billion and continue to rise to US$ 54.0 billion by 2015.

- The World Health Organization (WHO) Commission on Macroeconomics and Health estimate that an additional US$ 27 billion per annum in aid is needed to strengthen the capacity of health systems so that they can deliver basic health-care packages effectively. Meeting this target would require a five-fold increase in donor spending on health that does not include free access to ART for everyone in clinical need.

- The role of civil society is pivotal in the implementation of this target. The proliferation in the number of civil society partners, particularly the non-governmental organizations (NGOs) dealing with HIV/AIDS both at national and international level is a major concern. In the last ten years there has been a considerable increase in the number and range of NGOs specialising in HIV/AIDS work. By one reliable estimate, there are now more than 60,000 AIDS-related NGOs globally. The proliferation of AIDS-related NGOs has, at times, occurred at the expense of accountability and credibility. The existence of the

so-called "briefcase NGOs" in many countries undermines the credibility of the genuine NGOs.

- The role of the Department of Public Information (DPI) in creating public awareness on the issue of HIV/AIDS is pivotal in the fight against the HIV/AIDS pandemic worldwide. DPI has been involved in high-profile events aimed at mobilizing the media industry globally in the fight against HIV/AIDS. It is estimated that 5 to 10 per cent of the total coverage of DPI is devoted to HIV/AIDS-related activities. However, DPI does not have a clear-cut strategic framework and/or guidelines related to the dissemination of information on HIV/AIDS, despite the fact that formal meetings between the former Head of DPI and the Executive Director of UNAIDS have been conducted in the past with a view to reaching some kind of understanding on the modalities for cooperation between the two entities in the area of HIV/AIDS-related information coverage.

- In countries like Brazil, India, South Africa, Russia, Poland and Botswana that have plenty of financial resources of their own devoted to the fight against the HIV/AIDS pandemic, the only thing that the authorities in such countries would want to hear are excellent innovative ideas from the United Nations family that could assist them in making the fight against HIV/AIDS much more effective, efficient and sustainable in the long run. On the other hand, unfortunately, a good number of poorer developing countries continue to depend heavily on foreign bilateral donors as a reliable means of funding in support of the national response to HIV/AIDS. If unchecked, this will be an extremely dangerous trend in the long-term sustainability of the implementation of HIV/AIDS mandated programmes and activities.

- The international community and more particularly the United Nations system organizations seem to be increasingly optimistic about the future prospects for the fight against HIV/AIDS. However, after more than 100 meetings with representatives of Governments, NGOs, civil society, and with various officials from the United Nations system organizations in the countries visited, there is every reason to believe that the world is currently losing the battle against the HIV/AIDS pandemic. In other words, as new infections continue to outpace the global effort to prevent and treat patients, the need for an AIDS vaccine is more compelling today than at any time in the history of the pandemic.

Listed below are the recommendations for consideration by the legislative bodies of the relevant United Nations system organizations. Other recommendations (recommendations 3, 4, 5, 6, 7, 8, 9, 10 and 11), proposed for the consideration of the executive heads, can be found in the main text of the report.

Recommendations for consideration by legislative organs

➢ **The Economic and Social Council should review and strengthen the mandate of UNAIDS, including enhancing the authority of the secretariat, in order to effectively lead, coordinate and monitor the fight against HIV/AIDS and to ensure proper accountability of the Cosponsors to the joint programme. As part of the review, the number of Cosponsors should be restricted to the six original organizations/Cosponsors, namely, the United Nations Development Programme, WHO, the United Nations Population Fund, the United Nations Children's Fund, the United Nations Educational, Scientific and Cultural Organization and the World Bank. Other organizations could participate through the Cosponsors on the basis of a memorandum of understanding.**

➢ **The Economic and Social Council should review and revise the authority, role and responsibility of the UNAIDS Programme Coordinating Board, to enable it to have supervisory responsibility over the UNAIDS secretariat and the Cosponsors in relation to the joint programme on HIV/AIDS.**

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ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ANRS	National Agency for HIV/AIDS Research
ART	Antiretroviral therapy or antiretroviral treatment
ARV	Antiretroviral drug
CCM	Country coordinating mechanism
CCO	Committee of Cosponsoring Organizations
CO	Country office
CSWs	Commercial sex workers
EU	European Union
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GTT	Global Task Team
HIV	Human immunodeficiency virus
HVTN	The HIV vaccine trial network
IAVI	International AIDS Vaccine Initiative
IDUs	Injecting drug users
ILO	International Labour Organization
JIU	Joint Inspection Unit
M&E	Monitoring and evaluation
MDGs	Millennium Development Goals
MSMs	Men who have sex with men
NACA	National AIDS Coordinating Authority
NAC	National AIDS Council
NGO	Non-governmental organization
NIAID	National Institute of Allergy and Infectious Diseases
NSP	National Strategic Plan
PCB	Programme Coordinating Board of UNAIDS
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PRSPs	Poverty Reduction Strategy Papers
UBW	UNAIDS Unified Budget and Workplan
UCC	UNAIDS Country Coordinator
UCCs	UNAIDS Country Coordinators
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNTGs	United Nations Theme Groups
WFP	World Food Programme
WHO	World Health Organization
WRAIR	Walter Reed Army Institute of Research

I. INTRODUCTION

1. As part of its programme of work for 2006, the Joint Inspection Unit (JIU) conducted a review of the progress made by the United Nations organizations in achieving Millennium Development Goal (MDG) 6, target 7, to combat HIV/AIDS.

2. The objective of the review was to assess the progress made since the adoption of the United Nations Millennium Declaration in 2000. The review focused on the role and involvement of the UNAIDS secretariat and the Cosponsors and other stakeholders in the achievement of Goal 6, target 7, to have halted by 2015 and begun to reverse the spread of HIV/AIDS and to provide Member States with an objective assessment of the efficiency and effectiveness of the policies and programmes implemented and the bottlenecks in achieving this target. The review also assessed the effectiveness of coordination and cooperation among the various United Nations entities and other stakeholders involved in combating HIV/AIDS.

3. Epidemic diseases are not new; but what sets HIV/AIDS apart is its unprecedented negative impact on the social and economic development of nations. Everyone, rich or poor, young or old, could be affected. The majority infected are adults in the prime of their working and parenting lives. Their legacy is a decimated workforce, fractured and impoverished communities and millions of orphans.

4. In many developing countries, the effects of the HIV/AIDS pandemic, combined with the economic recessions of the 1970s and 1980s, have erased decades of demographic and economic progress and have seriously compromised the living conditions of future generations. HIV/AIDS has such a staggering impact because it weakens and kills many people in their young adulthood, the most productive years for income-generation and family caregiving. It collapses and breaks up families by eliminating the generation that is most important to the survival of society's youngest and oldest members. The pandemic affects every aspect of human life. It has imposed heavy burdens on individuals, families, communities and nations. The disease has wide-ranging impacts on families and households; agricultural sustainability; business; the health sector; education; and economic growth.[1] The pandemic will continue to have devastating consequences for decades to come for virtually every sector of society.

5. HIV/AIDS has a pervasive effect on the affected populations and the failure to hit the target on HIV/AIDS would negatively impact the achievement of other goals, especially those related to reducing child mortality, improving maternal health and eradicating extreme poverty and hunger. Only a large-scale and concerted effort and response by the countries affected, international organizations, donors, civil society and the private sector could counter a crisis of such scope and magnitude.

6. In accordance with the internal standards and guidelines of JIU and its internal working procedures, the methodology followed in preparing this report included a preliminary review, interviews and in-depth analysis. The Inspector conducted interviews with officials of the UNAIDS secretariat and the Cosponsors and also sought the views of a number of other stakeholders from other international organizations, non-governmental organizations (NGOs) and of representatives of Member States. Comments from participating organizations on the draft report have been sought and taken into account in finalizing the report.

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[1] The Impact of AIDS, Department of Economic and Social Affairs (ST/ESA/SER.A/229).

7. In accordance with article 11.2 of the JIU statute, this report has been finalized after consultation among the Inspectors so as to test its conclusions and recommendations against the collective wisdom of the Unit.

8. To facilitate the handling of the report and the implementation of its recommendations and the monitoring thereof, the annex contains a table indicating whether the report is submitted to the organizations concerned for action or for information. The table identifies those recommendations relevant for each organization, specifying whether they require a decision by the organization's legislative or governing body or can be acted upon by the organization's executive head.

9. The Inspector wishes to express his appreciation to all those who assisted him in the preparation of this report, and particularly to those who participated in the interviews and so willingly shared their knowledge and expertise.

II. IMPLEMENTATION OF THE MILLENNIUM DEVELOPMENT GOALS TARGET TO COMBAT HIV/AIDS

A. Declaration of political commitment

10. The United Nations system's concerted fight against HIV/AIDS started in 1986 when the World Health Organization (WHO) established the Global Programme on AIDS. The baton was passed on to the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996. The momentum in the fight gained support in September 2000, when the Member States resolved, among other Millennium Development Goals (Goal 6, Target 7) to have, by 2015, halted and begun to reverse the spread of HIV/AIDS (General Assembly resolution 55/2). The General Assembly in its resolution S-26/2 adopted the Declaration of Commitment on HIV/AIDS "Global Crisis – Global Action" the first global "battle plan" with key goals and targets for the international community in the fight against HIV/AIDS. The Declaration of Commitment is the foundation for concerted action in the following areas: strengthening leadership in combating HIV/AIDS; prevention of disease; provision of care, support and treatment; respect for the rights of people living with HIV (PLHIV); reducing vulnerability (especially of women and children); alleviating social and economic impact; investing in research (and development of treatment; addressing HIV/AIDS in conflict and disaster-affected regions; securing adequate resources; and establishing systems for monitoring and evaluation of progress achieved.

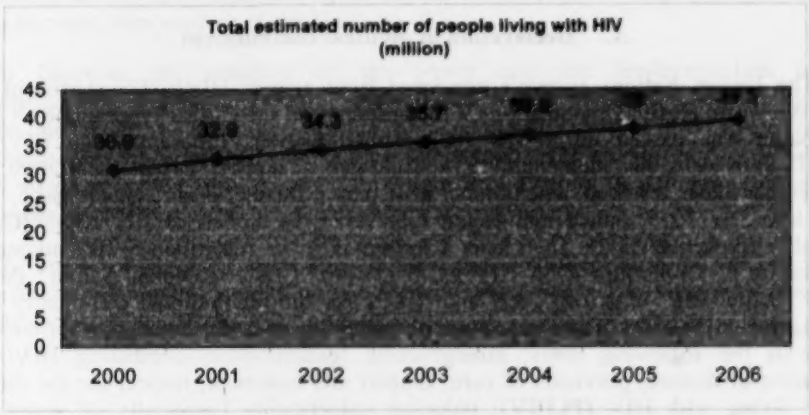
11. In 2005, through the adoption of the World Summit Outcome (General Assembly resolution 60/1), the Member States committed themselves inter alia to: (a) increase investment to improve health systems in developing countries and those with economies in transition to achieve the health related Millennium Development Goals by 2015; (b) fully implement all commitments established by the Declaration of Commitment on HIV/AIDS; and (c) promote long-term funding, including public-private partnerships, for academic and industrial research for the development of new vaccines. In June 2006 after the High-Level Meeting on AIDS, the Member States committed themselves, inter alia, to overcoming legal, regulatory or other barriers that block access to effective HIV prevention, treatment, care and support, medicines, commodities and services (Political Declaration on HIV/AIDS annexed to General Assembly resolution 60/262).

B. AIDS epidemic trend analysis[2]

12. HIV/AIDS knows no national or geographical boundaries. It kills globally. Since 1981, when the first cases of AIDS were diagnosed, AIDS-related mortality has reached orders of magnitude comparable to those associated with visitations of pestilence in earlier centuries. By the end of 2006, more than 25 million people had lost their lives to AIDS, and an estimated 39.5 million were living with HIV. In 2006 alone, there were 4.3 million new infections and 2.9 million deaths due to AIDS. The future course of the disease and its real magnitude remain unknown. The graph below indicates the global trend in the prevalence rate of the epidemic since adoption of the target in 2000.

[2] UNAIDS issued the 2007 AIDS epidemic update in November 2007. The prevalence rate has been significantly revised downwards for the year 2007 using an advanced methodology. Similar revisions have been done for the previous years. However for various purposes, the present report retains the data provided by UNAIDS in June 2007.

Table 1. Estimated number of people living with HIV 2000 - 2006



13. The increase in the number of people living with HIV in 2006 is approximately 28 per cent compared to the 2000 estimates. There is an upward trend in the prevalence of HIV infections since the adoption of the target. Similarly, a comparative analysis of the available data across the various regions of the world indicated the following trend.

Table 2. Regional data on people living with HIV 2000 and 2006

People living with HIV, regional data 2000 and 2006 (in millions)

	2000	**2006**
Sub-Saharan Africa	21.1	24.7
Middle East and North Africa	0.33	0.46
South and South-East Asia	5.9	7.8
East Asia	0.37	0.75
Oceania	0.04	0.08
Latin America	1.2	1.7
Caribbean	0.23	0.25
Eastern Europe and Central Asia	0.39	1.7
North America and Western Europe	1.6	2.1
Total	**31.2**	**39.5**

Source: AIDS epidemic update data files (UNAIDS/WHO, Dec 2006).

There is a steady increase across the globe in the number of PLHIV. The percentage increase ranges from 9 per cent in the Caribbean to 336 per cent in Eastern Europe and Central Asia. The other major percentage increases (in parenthesis) were noted in Sub-Saharan Africa (17), North America and Western Europe (31), South and South-East Asia (32) and Latin America (42).

C. Need to revise the mandate of UNAIDS

14. When UNAIDS was established in 1996, it was given a mandate to lead, coordinate and expand the United Nations global efforts in the fight against HIV/AIDS. UNAIDS was mandated to fulfil a number of functions, inter alia: (a) to provide global leadership in response to the pandemic; (b) to achieve and promote global consensus on policy and programmatic approaches; and (c) to advocate greater political commitment in responding

to the epidemic at the global and country levels.[3] More importantly, UNAIDS was charged with the responsibility of providing technical support and information, including best practices, epidemiological data, and other information on the national and international response to HIV/AIDS.

15. UNAIDS is the United Nations first joint co-sponsored programme of its kind that is intended to be a model of United Nations reform. UNAIDS is currently comprised of a secretariat and ten Cosponsors that act at the global, regional, country and local levels. The UNAIDS Programme Coordinating Board (PCB) acts as the governing body responsible for all programmatic issues concerning policy, strategy, finance, and monitoring and evaluation. The Committee of Cosponsoring Organizations (CCO), comprising of the Cosponsors' executive heads or their representatives, provides input into UNAIDS policies and strategies.

16. In the 10 years of its existence, the Inspector wishes to give due credit to UNAIDS, particularly the secretariat, for its invaluable contributions to the fight against HIV/ AIDS at the global level, which among others, include (a) increasing awareness among the national and international communities to enhance the response; (b) advocating and bringing in the necessary political commitment; (c) helping to reframe AIDS as a multi-sector issue rather than a health issue; (d) providing the requisite epidemiological data and information; (e) advocating for increased international/domestic funding; and (f) improving coordination among the numerous stakeholders at the global and national levels.

17. UNAIDS has yet to make a full impact in its country level efforts. There are major difficulties in fulfilling its responsibility to strengthen the capacity of affected nations to plan, coordinate, implement, and monitor the overall response to HIV/AIDS. The most important factor that limits the effective functioning of UNAIDS is its weak and outdated mandate. The Economic and Social Council established the mandate in 1994 when the pandemic was viewed as a health problem with limited impact. Thirteen years later, the situation has drastically changed. The severity of the pandemic is felt globally and there is a collective global response to it. While UNAIDS, now has a broad, dynamic and challenging responsibility with greater accountability to its stakeholders, its mandate has not been reviewed and/or revised. UNAIDS progress depends on actions taken by other entities/actors, such as national Governments, international donors and civil society over whom it has no institutional authority. The Inspector strongly believes, therefore, that the UNAIDS mandate needs to be enhanced and reinforced in order not only to face the challenges associated with the exigencies of the new realities, but also to ensure the achievement of this target by 2015. The Inspector also believes that the authority of UNAIDS secretariat needs to be enhanced for effective coordination.

D. Too many Cosponsors

18. According to their comparative advantage and expertise, UNAIDS brings together the respective efforts and resources of the Cosponsors in their common endeavours to prevent new HIV infections, care for those already infected, and mitigate the impact of the pandemic. Currently, there are 10 Cosponsors. When UNAIDS was established in 1996, there were only six; namely, the United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), WHO, the United Nations Educations, Scientific and Cultural Organization (UNESCO) and the World Bank. Subsequently, four more United Nation agencies were added to the list of Cosponsors; namely the United Nations Office on Drugs and Crime (UNODC) in 1999, the International Labour

[3] ECOSOC resolution 1994/24 of 26 July 1994.

Organization (ILO) in 2001, the World Food Programme (WFP) in 2003 and the United Nations High Commissioner for Refugees (UNHCR) in 2004.

19. In the opinion of the Inspector, the existing partnership of 10 Cosponsors is too many. As one representative of an NGO who was attending the PCB meeting noted recently: "There are too many agencies doing too many things". Importantly, as a joint and Cosponsored programme, the achievement of UNAIDS depends heavily on the understanding, cooperation, and consensus between the Cosponsors. The implications of a larger, more diverse partnership are many. Since each Cosponsor is accountable only to its own independent governing/executive board, neither the UNAIDS secretariat nor the PCB has any controlling organizational authority over the Cosponsors. Consequently, little can be done to exert pressure to bear on the Cosponsors to become effective partners within UNAIDS. In addition, there are governance implications in managing a growing CCO and participation in the PCB as it increases the consultative and collaborative initiatives, mechanisms and difficulties in consensus-building. Also, the increase in the number of Cosponsors has notable implications, not only in the allocation of the Unified Budget and Workplan (UBW) funds amongst them, but also in managerial implications for the UNAIDS secretariat in terms of its ability to successfully perform its coordination/facilitation functions at the global level. Some UNAIDS country coordinators (UCCs) continue to experience major difficulties in effectively coordinating the multitude of Cosponsors, even at the country level.

20. On the other hand, the problem is even further compounded, not only by the presence of relatively few Cosponsors in some countries, but also in terms of those agency heads whose regional responsibilities render them increasingly unable to attend theme groups as well as country team meetings on HIV/AIDS. For example, attending a United Nations country group meeting on HIV/AIDS in the capital of one of the highly affected countries in Southern Africa, the Inspector witnessed for himself the inability of UCC to continue with this particular meeting because of the lack of a quorum, due to the absence of several representatives of Cosponsors and/or United Nations agencies who were on mission outside the country.

21. More importantly, there is a certain degree of overlapping and duplication of activities among the Cosponsors at the country level. Prevention of mother-to-child transmission, which is a major prevention activity, is a vivid example of such a duplication of effort. Also, there is unhealthy competition for funding among the Cosponsors. The Inspector notes that, with the expanding global response to HIV/AIDS, there is every reason to believe that other United Nations system organizations would be interested in joining UNAIDS in the future. This should be strongly and unequivocally discouraged. Equally important is the need for the existing Cosponsors to be restricted to the six original organizations/Cosponsors, namely, UNDP, WHO, UNFPA, UNICEF, UNESCO and the World Bank. It is the Inspector's humble view that other interested United Nations system organizations could conveniently participate in any activities in support of UNAIDS through the existing Cosponsors. In other words, some kind of innovative mechanism would need putting in place to allow for such an engagement to take place in the future.

22. The implementation of the following recommendation is expected to enhance the effectiveness, coordination and accountability of UNAIDS.

Recommendation 1

The Economic and Social Council should review and strengthen the mandate of UNAIDS, including enhancing the authority of the secretariat, in order to effectively lead, coordinate and monitor the fight against HIV/AIDS and to ensure proper accountability of the Cosponsors to the joint programme. As part of the review, the number of Cosponsors should be restricted to the six original organizations/ Cosponsors, namely, UNDP, WHO, UNFPA, UNICEF, UNESCO and the World Bank. Other organizations can participate through the Cosponsors on the basis of a memorandum of understanding.

III. COORDINATION OF IMPLEMENTATION

23. The achievement of the target depends on the effectiveness and efficiency of the coordination between the various stakeholders at the global and country level. The changing pace of the international and national response, the increase in the new funding programmes and the proliferation of donors and funding mechanisms underscore the need for effective global and national coordination.

24. UNAIDS, as mandated by Economic and Social Council Resolution 1994/24, provides coordination at the global level with the primary aim of strengthening and supporting country-led response. The added value of UNAIDS, in addition to regional or country mechanisms, is in the ability to engage the broadest possible base of actors in a coherent and harmonized approach to the response to AIDS. However, UNAIDS' global coordination responsibilities face several challenges. There is a fragmented approach from the various stakeholders in terms of policies, processes and priorities. This unfortunate state of affairs has resulted in diverse opinions, independent governance structures and the subsequent funding of different activities at the country and regional levels, which have often skewed attempts at global priority setting. Indeed, this is further compounded by the lack of uniform accountability mechanisms for many stakeholders in respect of both country and global processes.

A. Global Coordination

Programme Coordination Board

25. The Programme Coordinating Board (PCB) acts as the governing body on all programmatic issues concerning policy, strategy, finance, monitoring and evaluation of UNAIDS. Currently, the PCB is composed of representatives of 22 Governments from all regions of the world, the 10 Cosponsors, and five NGOs, including associations of PLHIV. Representatives of Member States, NGOs, other United Nations bodies and intergovernmental organizations also attend PCB meetings as observers. The important functions of the PCB relating to the joint programming are (i) to establish broad policies and priorities; (ii) to decide upon their planning and execution; (iii) to approve the plan of action and budget for each financial period and arrangements for its financing; and (iv) to review longer term plans of action and their financial implications.

26. Since its constitution in July 1995, the PCB has held 20 meetings and has provided meaningful guidance and direction to UNAIDS. However, the effectiveness of the PCB is limited by several factors. In the existing institutional framework, the decisions of the PCB are not automatically binding on the Cosponsors. PCB decisions need to be endorsed by the governing bodies of all the Cosponsors before they can be implemented. This is a time-consuming process, which at times has a detrimental effect on the issues that needed to be acted upon immediately. The Inspector notes that in the existing PCB structure there are no mechanisms to ensure the accountability of members and partners with respect to the commitments made during Board sessions. On a number of occasions, this has led to slow implementation of actions that were urgently needed to further the response to AIDS.

27. In the context of the expanding global response private foundations, the research community and the corporate sector have emerged as new stakeholders and are playing a significant role, however they have no formal role in the PCB. For instance, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), maintains some form of relationship with the PCB. However, the existing relationships need to be institutionalized to ensure meaningful involvement. Furthermore, while the participation of civil society in the PCB is a salient

feature of the governance structure of UNAIDS, problems regarding the selection process for NGOs, accountability and representation need also to be addressed.

Committee of Cosponsoring Organizations (CCO)

28. The Committee of Cosponsoring Organizations, consisting of the 10 Cosponsors, is mandated to ensure the overall coherence of the joint and individual activities of the Cosponsors through commitment at the executive level. The CCO formally meets twice a year and its authority is limited: it is neither an executive nor a monitoring body. It only endorses the budget and the workplan of UNAIDS and has authority only for activities financed from the UBW. It has no authority over the programmes on HIV and AIDS of the individual Cosponsors, nor is it a joint decision-making body for the UNAIDS secretariat and the Cosponsors. Although it is a standing committee of the PCB, it nevertheless does not have a clear accountability framework since it is not directly accountable to the PCB.

Global Task Team

29. The Global Task Team on improving AIDS coordination among multilateral donors and international donors (GTT),[4] made a number of recommendations to strengthen coordination, to simplify and harmonize procedures and to align support more closely with countries' needs and priorities. The set of rather complex recommendations made by the GTT is focused around four areas: empowering national leadership and ownership; harmonisation and alignment; reform for a more effective multilateral response; and accountability and oversight. The majority of the recommendations are directed at multilateral agencies; however, the central role of the National AIDS Councils (NACs) at country level is important to the successful implementation of these recommendations. The Inspector notes that implementing the GTT recommendations involves: (a) improving coordination between the sources of funding; (b) agreeing on a specific programme of technical support with various Cosponsors taking the lead in different technical areas; and (c) establishing the Global Implementation Support Team (GIST).

Division of labour

30. The division of labour for technical support among the Cosponsors, as recommended by the GTT, is a major step in enhancing an effective coordination process. Prior to the adoption of this recommendation, the Cosponsors have been providing piecemeal, parallel and sometimes competitive support to the countries. The division of labour is intended to provide a unitary, unified and consolidated technical support plan. It falls under 17 technical support areas with a lead organization for each of these areas, and with the involvement of the main partners. The lead organization concept provides clarity in identifying which Cosponsor is responsible for providing technical support in a particular area. The lead organization serves as a single entry point for government and other relevant country-level stakeholders to access the required technical support with the support of other Cosponsors.

31. Despite this recent initiative for more country-specific division of labour, the extent to which it will strengthen coordination at the country level remains to be seen. During discussions on his field visits, the Inspector noted many difficulties in implementing the division of labour. There is clearly a lack of awareness and clarity among the various

[4] Established by the high-level meeting attended by leaders from Governments, civil society, United Nations agencies, and other multinational and international institutions on the theme "Making the Money Work" held in London on 9 March 2005. The GTT is composed of representatives from 24 countries and institutions, including Governments of developing and developed countries, civil society, regional bodies and multilateral institutions.

stakeholders at the country level, particularly among the various government departments and civil society partners on the division of labour and its modalities. This is further exacerbated by the lack of clarity on the lead agency concept among the United Nations country teams, due to the overlapping mandate of the Cosponsors. There are overlapping issues in the division of labour, such as the prevention of mother-to-child transmission, women and children, youth and prevention efforts that have remained unresolved among the Cosponsors. Also, the Headquarters of the various Cosponsors have issued contradictory guidelines with regard to the role of their respective representatives in their countries of accreditation, thus creating confusion at the country level.

32. The implementation of the following recommendation is expected to enhance the effectiveness, coordination and accountability of UNAIDS at global level.

Recommendation 2

The Economic and Social Council should review and revise the authority, role and responsibility of the UNAIDS Programme Coordinating Board, in order to enable it to have supervisory responsibility over the UNAIDS secretariat and its Cosponsors in relation to the joint programme on HIV/AIDS.

B. Coordination at the Country Level

33. In its resolution 1994/24 the Economic and Social Council clearly mandates that country level operations be at the forefront of the activities of UNAIDS. Coordination at country level has many actors and different dimensions. The coordinating responsibility of UNAIDS is to support specific objectives, such as a national strategic plan, political commitment and resource allocation. There is also the functioning of the United Nations Theme Groups (UNTGs), the development of integrated workplans for Cosponsors, and the link between this and other United Nations processes, such as the Common Country Assessment (CCA) and United Nations Development Assistance Framework (UNDAF). The other significant responsibilities are the promotion of country-owned coordinating processes such as NACs and other multisectoral forums and the need to ensure their effective functioning. In order to ensure effective functioning of all HIV/AIDS-related activities at the country level, the responsibilities of UNAIDS, among others, should also include resource mobilization efforts through innovative financing mechanisms and/or strategies, on behalf of the developing countries that are highly affected by the pandemic.

United Nations system coordination

34. The United Nations Theme Groups on HIV/ AIDS, anchored under the resident coordinator system, were the lead mechanism at the country level. With membership drawn from heads of agencies of both Cosponsors and non-Cosponsors, the main role of the UNTGs was to advocate and facilitate coordination among Cosponsors and to develop joint programmes. The performance of the UNTGs has varied widely across countries with variation in terms of structure, frequency of meetings and of its membership. As initially constituted, the UNTGs were not successful in undertaking the tasks that were expected of them. The composition of the UNTGs was later expanded to include government officials, donors, civil society and the private sector. However, the UNTGs were largely ineffective on account of the lack of coordination and poor results arose from the overlapping mandates of UNTG members together with inconsistent technical and policy advice on HIV-related issues.

However, one of the achievements of the UNTGs was the successful preparation and formulation of strategic plans/frameworks in many countries.

35. To support the UNTGs, the UNAIDS secretariat established country offices (COs) and appointed country coordinators (UCCs) in assisting the UNTG chairs in taking forward issues of coordination between Cosponsors, and in strengthening United Nations system relations with country counterparts and other stakeholders. Currently, there are UCCs in more than 75 countries. Their role is a complicated and challenging responsibility, but in the countries visited the Inspector noted the major and significant role played by the UCCs in effectively coordinating the activities of the national response. However, a harmonious relationship between the United Nations Resident Coordinator, the chair of the United Nations Theme Group, and the UNAIDS Country Coordinator remains a big challenge in some countries.

36. Also, it is a matter of fact that COs were not established in many countries; and a good number of UCCs and heads of agencies neither speak the local languages nor understand the cultural sensitivities of the countries concerned - an important element in efforts towards forging any closer cooperation and collaboration with the host countries in dealing with such a sensitive and increasingly volatile matter as the HIV/AIDS pandemic is believed to be. Consequently, for the purpose of ensuring effective representation and credibility in the eyes of the host countries, UNAIDS and the Cosponsors, in the selection process of UCCs and agency heads in each country of accreditation, should take due consideration of the cultural sensitivities and local languages of the host countries concerned by matching them with the political, cultural and diplomatic credentials of the selected future UCCs and the agency heads concerned.

37. The GTT noted that the coordination at the country level was uneven and the UNTGs had not succeeded in establishing a truly joint programme that included the AIDS activities of all UNAIDS Cosponsors. The GTT further noted that the national partners engaged Cosponsors separately, rather than accessing a joint programme. In December 2005, the Secretary-General instructed the Resident Coordinators to establish joint United Nations teams on AIDS as recommended by the GTT. The establishment of joint teams is expected to improve United Nations system performance in terms of effective harmonization and alignment of national responses and to delivering coordinated technical support.

38. The Inspector noted that Joint United Nations Teams on AIDS had been established in 63 countries as of February 2007. However, significant challenges still remained with regard to the efficient functioning of joint teams in the countries visited. Indeed, the joint teams placed additional workload on those agencies with a small field presence at country level. Many of the officials had regional responsibilities that made them often unable to dedicate time and resources to attend Team meetings on a regular basis. While the concept of one United Nations family working together under one roof could be very instrumental in terms of ensuring effective coordination and collaboration among the Cosponsors, the Inspector noted with great concern that in some countries visited, such a concept may be difficult to implement because the costs associated with it, such as office rent etc., are increasingly unaffordable to some agencies. This is especially so for those agencies that can conveniently find less expensive and/or rent-free office space elsewhere. In other words, the United Nations should put more emphasis on substance rather than on mere cosmetic nuances and niceties.

39. More importantly, there were differences in commitment to joint working and in skills and capacities between the Cosponsors. In some countries, there was an evident duplication of roles and representation between the United Nations Theme Group on AIDS and the Joint Team on AIDS; consequently, their respective roles were not well understood by stakeholders outside the United Nations system. The Inspector also noted that the accountability

mechanisms for the Joint Teams have not been clearly established. The coexistence of parallel accountability mechanisms is of great concern and needs to be addressed. The Inspector noted that individual staff members report directly to their respective agency heads; while the Joint Teams and UNTG reported to the Resident Coordinator, and UCCs reported to the UNAIDS secretariat.

40. Importantly, it is regrettable to note that only limited progress has been made with regard to joint programming, as a result of the inability of country teams to allocate adequate time to developing joint programmes due to overlapping priorities, like the UNDAF and country planning cycles which provide the support for the joint programmes. The main challenges facing joint programming include the continued development of joint plans based on individual United Nations agency imperatives and priorities, rather than the development of integrated joint plans that are based on national needs and priorities. There is also a lack of clear directives and support from agency headquarters and heads of agency in the countries concerned on how to establish and implement joint programmes. The Inspector noted that lack of staff and agency capacity in developing and implementing joint programmes, and the differences in Cosponsor planning cycles and financial, administrative and operational procedures, have increasingly become the major impediments to efforts to ensure the effective implementation of joint programming.

41. The implementation of the following recommendation is expected to enhance the efficiency and effectiveness of UNAIDS at country level.

Recommendation 3

In order to enhance the effectiveness of the UNAIDS at the country level, the executive heads of the UNAIDS secretariat and the Cosponsors should:

(a) Select suitable UNAIDS country coordinators and agency heads in each country of accreditation, matching their political, cultural and diplomatic credentials with due consideration to cultural sensitivities and the local languages of the host countries;

(b) Establish a harmonized and/or unified reporting mechanism for the United Nations country teams;

(c) Undertake deliberate and concerted efforts to ensure the effective implementation of joint programmes.

C. Country Level Mechanisms

Application of the "Three Ones" principles

42. The "Three ones" principles emerged during 2003-2004 and marked a significant change in the global response to HIV/AIDS. This period was characterized by a shift towards acknowledgement of the pandemic rather than denial by many Member States, and the demand for concerted action to address the pandemic. The availability of funding increased dramatically, along with an urgent desire to reduce duplication and fragmentation in order to effectively manage resources at the country level. At that time, the optimal use of resources was limited in the affected countries by a lack of coordination among government ministries, international aid agencies, community-based organizations and other players. Various stakeholders engaged in parallel financing, planning, programming and monitoring. Inevitably, this weakened the national response in the affected countries.

43. To address these problems, in September 2003, at the 13th International Conference on AIDS and STIs in Africa, a working group approved a set of guiding principles for optimizing the use of resources and improving the country-level response to AIDS. In April 2004, the Consultation on Harmonization of International AIDS Funding bringing together representatives from Governments, donors, international organizations and civil society endorsed the Three Ones principles. The Three Ones were endorsed by the UNAIDS Programme Coordinating Board (PCB) in June 2004. Since then, the Three Ones principles have gathered pace. They can be described as: (a) one agreed strategic HIV/AIDS action framework that provides the basis for coordinating the work of all partners; (b) one national AIDS coordinating authority, with a broad-based multi-sectoral mandate; and (c) one agreed country-level monitoring and evaluation system. UNAIDS acts as facilitator and mediator in the efforts towards the realization of these principles.

44. Many stakeholders at both national and global levels have accepted the Three Ones principles. They are not prescriptive, but rather they are guidelines designed to offer countries a basis for improving the roles and relationships among the various stakeholders. Indeed, they are meant to harmonize and coordinate national responses to HIV and AIDS, and in particular, to increase national ownership and accountability. More importantly, they are intended to bring about effective coordination and coherence to the response to AIDS.

45. Achieving full application of the Three Ones principles is a key priority of the United Nations system, including the World Bank. However, there are some notable challenges with regard to their full application. For instance, while at the country level, the United Nations Theme Groups have incorporated Three Ones actions into their workplans and UNAIDS has played an instrumental role in providing concrete support to the harmonization of coordinating mechanisms and to strengthening monitoring and reporting mechanisms, many bottlenecks remain to be addressed and continue to impact the full application of the Three Ones. Also, capacity constraints in many countries have continued to severely undermine their effective application.

46. One of the key challenges for the effective implementation of the Three Ones principles at the country level is the existence of many coordination structures with overlapping membership and focus, often without any link between consultation and decision-making structures and processes. A typical example of overlap is between the National AIDS Councils (NACs) and the country coordinating mechanisms (CCMs) of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Although the GFATM is attempting to harmonize its systems so that grants can fit into national AIDS structures as seen in Mozambique, the progress in aligning systems remains slow. The overlap and confusion of roles between NACs and CCMs is adversely affecting grant performance in certain countries. More importantly, the continued failure of GFATM to share the reports of its local fund agents with the representatives of Governments and United Nations system organizations concerned at the country level is another bottleneck that puts into question and/or defeats the very purpose of the transparent nature of the whole GFATM process.

One agreed AIDS action framework

47. Since their endorsement, almost all Member States most heavily affected by the pandemic have embarked on applying the Three Ones principles. It is estimated that 85 per cent of affected countries have national AIDS action frameworks or national strategic plans (NSPs). Most of the Member States that had already established some sort of national action plan have revised them into a long-term strategic framework. The Botswana National HIV/AIDS Framework (2003-2010), the Uganda National AIDS plan (2007/2008 to 2011/2012) and the Kenya National Strategic Plan (2005/2006–2009/2010) are some of the

few examples in sub-Saharan Africa. The Inspector noted that the nationally led and participatory planning and review procedures are becoming more common in establishing these strategic frameworks or NSPs. There is broad participation, bringing in key government ministries, bilateral and multilateral donors, international institutions, and civil society in finalizing the framework. This brings in the required ownership of the various stakeholders and ensures comprehensiveness and quality in the framework.

48. However, the mere establishment of NSPs is not sufficient. NSPs will be of limited use unless they are fully costed, with workplans translated into practical plans suitable for regional/grass-roots implementation, and budgets that specify sources and allocation of funds. Many of the frameworks are not translated into workplans and budgets; it is estimated that only 60 per cent of the frameworks are costed and budgeted. Similarly, only 52 per cent have been translated into an operational plan and/or annual priority action plan. Many Member States have difficulty in translating national plans into actionable regional/grass-root level plans. The absence of costing, clear priorities and operational plans undermines the value of the frameworks in providing overall strategic and programmatic guidance for the national AIDS response. Without these elements, donors may not be able to align their funding to national priorities and may continue with the project mode of aid delivery with a vague reference to the strategic frameworks or NSPs.

49. One of the major drawbacks in most NSPs is the exclusion of the needs of marginalized and vulnerable populations - such as men who have sex with men (MSM), commercial sex workers (CSWs) and injecting drug users (IDUs) – who are key to all responses to HIV/AIDS. The UNAIDS/WHO 2006 AIDS epidemic update[5] noted that these high-risk behaviours significantly contributed to the increase in HIV prevalence rates across the globe in 2005. In Eastern Europe and Central Asia, 67 per cent of prevalent HIV infections were due to IDUs, 12 per cent due to CSW and 4 per cent due to MSM. In South and South-East Asia, 49 per cent of HIV infections were from CSW, 22 per cent from IDUs and 5 per cent from MSM. In Latin America it was 26 per cent from MSM, 19 per cent from IDUs and 17 per cent from CSWs. Despite their high-risk behaviour, these groups are excluded from the NSPs due to the nature of the behaviour of the affected people. All the Cosponsors, in close collaboration with the UNAIDS Country Coordinators, should see to it that these groups of affected people are included in the NSPs of the affected countries concerned.

One national AIDS coordinating authority

50. The most common vehicle for achieving the second of the Three Ones in many countries is the National AIDS Council (NAC). Most NACs were established and mandated by an act of the parliament or the legislature of the country concerned. In countries severely affected by the pandemic, NACs are in most cases operating under the office of the President or the Prime Minister to provide the requisite authority. In some countries, they report directly to the Minister of Health. While this is an important achievement, the functionality of this structure and how stakeholders are able to align with it will define its role in achieving country level results.

51. The Inspector recognises that the establishment and maintenance of a broad-based NAC, with the involvement of diverse stakeholders, is a political as well as a technical issue with its related problems. The Inspector believes that it would be too ambitious to create a new multi-sectoral mechanism with a responsibility to lead and coordinate well-established and powerful stakeholders. The launching of an infant NAC mechanism into a complex and highly politicised national AIDS response has caused tensions and frustrations among the various

[5] Available at http://www.who.int/hiv/mediacentre/2006_EpiUpdate_en.pdf

stakeholders, and in some cases has lost their support. In many donor-dependent countries, donor conditionality has influenced the speed with which NACs were established, as well as their organizational structure, without full acceptance by the countries concerned.

52. The role and responsibilities of NACs are also not well defined. Many NACs have been charged with a broad portfolio of responsibilities - strategic direction, coordinating the national response, resource mobilization, mainstreaming HIV/AIDS and donor coordination. In some countries, NACs act as a project-implementing agency. Also, there are other AIDS coordinating mechanisms at the country level, such as the CCMs of GFATM, which often find themselves in direct conflict with the role of the NACs. In some countries, the NAC is responsible for funding the national response, which raises expectations and exacerbates tensions with other ministries, as well as overwhelming the staff with work for which they are neither prepared nor adequately equipped.

53. The coordinating role and responsibilities of the NACs also needs to be strengthened. During his field visits and discussions, the Inspector observed significant difficulties in overseeing and coordinating the national response by the NACs. The NACs are established with an ambitious mandate to coordinate responses from non-government sectors including the United Nations system, civil society and the private sector, which is quite new to the normal remit of government agencies. Government agencies, which are usually involved in sector policy-making and programme implementation/service delivery, find it increasingly challenging and at times even frustrating to coordinate other sectors.

54. The NACs are, in most cases, placed under the office of the President or the Prime Minister to demonstrate political commitment and to provide them with greater authority and independence from other arms of government so they can effectively coordinate other sectors; however, in reality, there is a lack of clarity with regard to their role vis-à-vis the line ministries, as well as their role and potential contribution to the implementation of HIV/AIDS-related targets. This gap particularly affects the mainstreaming efforts of NACs to include HIV/AIDS as part of the plans of individual Ministries. The Inspector also observed that in many countries, there is confusion and often perceived competition between the roles of the Ministry of Health and the Ministry of Finance and Planning, that has sometimes put NACs in direct conflict with those entities that they are expected to lead and coordinate.

55. The Inspector notes that the primary objective of the membership of the NACs is to provide broad-based representation and a partnership bringing together State and non-State actors to mobilize their constituents and to ensure good governance practice in directing and overseeing the work of the NACs. In reality, this dual role is problematic for many NACs because each role requires different skill sets and different types of representation from their respective constituents.

One agreed country-level monitoring and evaluation system

56. Monitoring and evaluation (M&E) ensures that the national plan responds to the needs of the country concerned. Monitoring the epidemic and the response to it makes it possible for national AIDS authorities to allocate their limited resources to best advantage, and to respond to emerging trends in a timely manner. Evaluating programmes enables them to learn whether they are achieving their objectives and, if not, to take appropriate action to improve or replace them. The key steps towards an effective M&E system include: (a) developing an M&E framework, with key indicators, aligned to the national strategy; (b) preparing a detailed M&E operational plan and budget, with clear implementation procedures; (c) developing and maintaining a functioning M&E system, with a functioning database populated by epidemiological and programmatic data.

57. Viewed against these steps, most Member States have started to develop a unified monitoring and evaluation framework. Although there is a long way to go before an effective M&E system is established, many Member States are establishing working groups composed of representatives from Government, donor agencies, civil society, the United Nations system, and academic institutions. These groups are seeking to identify and adapt the indicators most appropriate for their countries, and to harmonize the collection, analysis and reporting of the data needed for M&E. These groups have had to address the current disconnect in M&E systems, whereby there are national level systems and hundreds of different donor/civil society systems.

58. Despite some progress, important challenges for M&E remain: national monitoring and evaluation strategies are not always aligned to the national framework or NSPs, because many national strategies lack a focus on results and sometimes lack grounding in epidemiology. Also the M&E partner community has developed separate strategies that are often delinked from national HIV/AIDS policies and plans. A significant number of countries still do not have a funded, functioning M&E system, which has been developed through partner coordination. This is the case in many countries situated in regions with less access to technical assistance, including parts of Central and West Africa, Central Asia, the Middle East and North Africa, and the Pacific.

59. Shortcomings in M&E systems represent one of the most pressing challenges standing in the way of achieving the targets set by the Millennium Development Goals. The challenges include weak collaboration among stakeholders, shortage of M&E skills, insufficient financial and other resources for M&E, and the absence of well-functioning systems for collecting, analyzing and reporting on the data needed for M&E. UNAIDS should, therefore, undertake appropriate measures to ensure that Member States that have not yet put in place a well-functioning M&E system do so as soon as possible.

60. The implementation of the following recommendation is expected to enhance the effectiveness, coordination and accountability of UNAIDS at country level.

Recommendation 4

In order to enhance the effectiveness of Three Ones principles, the Executive Heads of the UNAIDS secretariat and the Cosponsors should assist the affected Member States to:

(a) Ensure that the national strategic plans of the affected Member States are revised in conformity with these principles, are costed with detailed workplans and include the marginalized and vulnerable populations, as well as refugees, in the national strategic frameworks;

(b) Ensure that the National AIDS Councils are established effectively with limited membership and with well-defined and clear roles and responsibilities;

(c) Ensure that the Member States undertake appropriate measures to put in place a well-functioning monitoring and evaluation mechanism and provide adequate technical support.

IV. ACCESS TO ANTIRETROVIRAL THERAPY

The 3 by 5 Initiative

61. By the end of 2003, it was estimated that only seven per cent of the six million HIV-infected people in need of antiretroviral therapy (ART) in developing countries were receiving it, with the biggest gap being in Africa. The 3 by 5 Initiative, launched by the UNAIDS secretariat and WHO in 2003, was one of the major efforts of the multilateral organizations to translate its resolutions into a global effort to politically mobilize and technically support large-scale expansion of ART where it was needed most. The initiative was intended to mobilize the international community to address the global inequity in access to antiretroviral therapy. All stakeholders endorsed it in 2004, and WHO undertook an ambitious, two-year programme of work to help countries scale up antiretroviral therapy as part of comprehensive national responses to the HIV/AIDS epidemic.

62. The target of the initiative was to treat three million people living with HIV/AIDS in low- and middle-income countries by the end of 2005. This target was based on the belief that it would be feasible to provide ART to 50 per cent of those who needed it. This was considered a necessary, achievable milestone on the way to the ultimate goal of universal access. The strategy aimed at increasing the numbers of people who are receiving ART, strengthening health systems and intensifying prevention efforts. The initiative was pursued through five strategic objectives (the 3 by 5 pillars): (a) global leadership, strong partnership and advocacy; (b) urgent, sustained country support; (c) simplified, standardized tools for delivering ART (the public health approach); (d) effective, reliable supply of medicines and diagnostics; and (e) rapid identification and reapplication of new knowledge and success (learning by doing).[6] The funding gap to achieve this goal was estimated to be at least US$ 5.5 billion, which was expected to come from multiple sources, including the national budgets of low and middle-income countries, multilateral and bilateral donors.

63. The Inspector noted that the initiative has achieved a limited amount. It was estimated that by December 2005, only 1.3 million people were under ART, about 20 percent of the number of people needing ART as shown in the table[7] below.

Table 3. Estimated number of people receiving antiretroviral therapy 2003 - 2005

Geographical region	Estimated number of people receiving ART December 2003	Estimated number of people receiving ART December 2005	Estimated number of people needing ART December 2005	Percentage of ART Coverage
Sub-Saharan Africa	100,000 [75,000–125,000]	810,000 [730,000–890,000]	4,700,000	17
Latin America/ Caribbean	210,000 [160,000–260,000]	315,000 [295,000–335,000]	465,000	68
East, South Asia	70,000 [52,000–88,000]	180,000 [150,000–210,000]	1,100,000	16
Europe and Central Asia	15,000 [11,000–19,000]	21,000 [20,000–22,000]	160,000	13
North Africa Middle East	1,000 [750–1,250]	4,000 [3,000–5,000]	75,000	5
Total	400,000 [300,000–500,000]	1,330,000 [1,200,000–1,460,000]	6,500,000	20

[6] *Treating 3 million by 2005 - Making it happen*, WHO strategy document 2003.

[7] Information obtained from *Evaluation of WHO's contribution to "3 by 5"*, May 2006.

64. The Inspector also noted that the significant achievement of the initiative was that it showed that with significant mobilization of resources and efforts from various stakeholders, antiretroviral therapy could be provided in even the most resource-constrained settings such as sub-Saharan Africa. However, the striking differences between regions in the percentage of ART coverage of the needy population underscore the fact that many countries are far from containing their growing AIDS pandemic. Sustaining this response even at current levels remains one of their biggest concerns. The Inspector also noted that new HIV infections are continuing to rise in many settings, adding to the global burden of AIDS. It is estimated that for every person brought under ART, there are six new infections. Prevention was an area within the 3 by 5 Initiative that received relatively little investment. Thus effective prevention interventions, such as, for example, mother-to-child transmission, were not properly prioritized.

65. One of the lessons learnt is that the 3 by 5 global target has made the idea of a universal access goal possible – even though this target was not reached. Future targets, like the Millennium Development Goals and the goals and targets of the United Nations General Assembly Special Session on HIV/AIDS need to be realistic and country-owned if they are to serve as beacons for planning and measuring progress. Disaggregated sub-targets are needed for subpopulations to guide equitable access and specific prevention targets should be duly and timely considered if the goal of universal access in providing treatment, care and support to all affected people is to be achieved.

Universal access to prevention, treatment, care and support

66. Universal access to care and prevention is the successor programme to the 3 by 5 Initiative. Member States have committed to a massive scaling up of HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all who need it,[8] including refugees and/or internally displaced persons (IDPs). Unfortunately, with the exception of Tanzania and a few other countries, most affected countries seem to place little emphasis on, or show no interest at all in, including refugees in their policy framework documents. As a result, there are a significant number of refugees worldwide who continue to suffer simply because of being refugees. It is, therefore, the Inspector's view that the United Nations should continue to play an increasing role to ensure that refugees are also included in the strategic policy framework documents of all the affected countries, without any discrimination, for the purpose of providing universal access to treatment, care and support.

67. The concept of universal access implies also that all people should be able to have access to information and services. The global commitment to universal access by 2010, if realised, will lessen a major burden on Member States. The Inspector believes that universal access will result in people staying healthier and being able to live socially and economically productive lives as well as keeping parents alive to care for their children. However, for a chronic disease like AIDS, 2010 is a relatively short time horizon, and it may be useful to project the challenge over a longer term period, for example at least up to 2015. As this is an ambitious goal that provides lifelong support, the scaling up towards universal access should be equitable, accessible, affordable, comprehensive and sustainable.

68. The Inspector is mindful of the fact that the rate at which people get infected still exceeds the speed at which people can be put on treatment. According to the current estimate, there are six new infections for every one person put on ART. Unless the rate of new

[8] See General Assembly resolution 60/1, 2005 World Summit Outcome.

infections can be dramatically reduced in the years to come, the affected Member States will only move further away from universal access. Furthermore, the Inspector believes that affected Member States must move beyond the focus on ART supply and confront the social and economic conditions which pose obstacles to access and optimal health outcomes. Based on his field visits and discussions with the various stakeholders, the Inspector believes that the major challenges, as explained in the succeeding paragraphs, need to be addressed to ensure that universal access becomes a reality and positive health outcomes for all PLHIV are guaranteed.

Coverage of treatment

69. Improving access to HIV treatment is crucial to fighting the spread of HIV and improving the lives of people living with the virus. However, it has been well established that access to ART differs dramatically between and within countries. For example, Botswana and Uganda, where the Governments rapidly responded to treatment needs, are now treating more than half of those requiring ART. In other countries, like Tanzania, the coverage is low. Furthermore, within the countries, the access to ART has been easy in urban centres, whereas patients in the rural areas have limited or no access. In Kenya, both the northern and the north-eastern regions were found to have very limited access to treatment. In South Africa, most people receiving treatment were concentrated in a few provinces. To ensure equitable access, the coverage of treatment sites has to be nationwide.

70. Importantly, universal access to ART requires better accessibility to HIV testing and counselling. The Inspector also understood that there were difficulties in making available diagnostic kits to the regions and the districts. This implies that not many people are aware of their HIV status. If people are not aware that they are HIV positive, they will only find out that they require treatment when they are seriously ill, which may already be too late. In consequence, the recent launching of a high-profile national voluntary HIV/AIDS testing scheme by the President of Tanzania who, along with his wife, was the first person to be publicly tested and the Government of Malawi's call to all sexually active people in the country to take an AIDS test, are excellent examples of leadership and government commitment to pioneering and steering a nationwide campaign in the fight against the HIV/AIDS pandemic that should be emulated elsewhere.

71. More importantly, business communities in all Member States should be urged to support HIV/AIDS voluntary testing initiatives by encouraging their employees to go for testing. With the implementation of Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria programmes, such as the Blueprint for Business Action on HIV/AIDS, which are already common in many countries, the spread of HIV/AIDS at the workplace will be substantially decreased. Indeed, through voluntary testing, Member States will be afforded an opportunity to plan better and more effective intervention programmes. The adoption of the newest technology in HIV/AIDS testing, such as a simple finger prick now available in most developed countries, could also help to have many people tested. UNAIDS should, therefore, take cognizance of this reality by strongly advocating the need for the launching of national campaigns for voluntary HIV/AIDS testing in the affected countries and assist Governments to develop policies and programmes aimed at encouraging their citizens to voluntarily take HIV/AIDS tests.

Procurement and supply management

72. The need for better and more equitable access to ART programmes should be further supported by effective and efficient procurement and supply management. As scale-up continues, increasing numbers of patients are brought into ART programmes, underlining the need for the establishment of systems to procure and manage the supply of antiretroviral drugs (ARVs). Continuity in the provision of ARVs is crucial to the success of ART programmes. Any disruption in the procurement and supply will diminish the likelihood of positive health outcomes for individual users and will threaten the sustainability of ART programmes. The Inspector noticed the problem of lack of adequate stocks of ARVs and inadequate storage facilities in many places visited. This problem is particularly evident in the regional and district level facilities.

73. The problems in the procurement of ARVs relate to the lack of coordination between national authorities, civil society and donors. The procurement procedures of the affected Member States are quite different and at times contradictory to the requirements of the donors. This delays procurement and on many occasions creates tension between Member States and donors. The high cost of ARVs further exacerbates the procurement problems. Many of the affected Member States have found it increasingly difficult to procure cheap drugs due to their limited availability and doubts about their quality. Harmonization of procurement procedures at the country level would, therefore, be an important step in the right direction in terms of not only expediting the process of procuring the necessary drugs, but also in efforts to avoid unnecessary tension between the recipient and donor countries.

National health systems

74. Well-functioning, integrated, and fully operating public health systems at local, regional and national levels are a prerequisite for the successful roll-out of ART programmes. The national health systems in many of the affected Member States are facing an unprecedented challenge due to a lack of investment in health services and the rapid scale-up of ART. National health systems that were set up mainly to deliver short-term maternal and child health services suddenly have to cater for large numbers of PLHIV in need of lifelong chronic disease care. This has put an enormous strain on the already broken down and/or neglected public health systems in most of the affected Member States, which they find extremely difficult to cope with.

75. Furthermore, in most of the African countries visited, ART programmes are administered outside the reproductive health programmes, thus requiring additional health facilities. A significant proportion of donor funding, such as the United States President's Emergency Plan for AIDS Relief (PEPFAR), is devoted to improving the necessary infrastructure in hospitals and health facilities in the affected Member States; however, Governments should be encouraged to ensure that long-term plans are put in place, in order to sustain national health systems by seeking alternative ways of maintaining health service delivery in the future. More importantly, the Inspector believes that ART programmes should not be segregated, but should be integrated into sexual and reproductive health programmes and treatment services for tuberculosis and malaria.

76. The implementation of the following recommendation is expected to enhance the effectiveness, coordination and accountability of UNAIDS at country level.

Recommendation 5

In order to enhance the effective implementation of the universal access to the antiretroviral therapy, the executive heads of the UNAIDS secretariat and the Cosponsors should:

(a) Strongly advocate the need for the launching of aggressive national campaigns for voluntary HIV/AIDS testing and assist the affected Member States to develop policies and programmes aimed at encouraging their citizens to voluntarily take HIV/AIDS testing;

(b) Assist the affected Member States to ensure the harmonization of procurement procedures at the country level, as well as in establishing efficient supply management;

(c) Assist the affected Member States to ensure that antiretroviral therapy programmes are integrated into the sexual and reproductive health programmes and treatment services for tuberculosis and malaria.

The problem of brain drain

77. Inadequate numbers of health workers are a major constraint to the rapid scaling-up of ART programmes. The shortage of health workers in Uganda, Kenya, Botswana, South Africa, Tanzania and Poland has undermined possibilities of scaling-up. The shortage has placed additional pressures on already undersized and overburdened workforces. The availability of medical doctors and nurses against the number of PLHIV in these countries ranges from hundred to few thousands. The reasons are too many. In the most affected sub-Saharan African countries, many health professionals have died due to AIDS. The Inspector noted that the expansion in labour markets has intensified professional concentration in urban areas and migration within regions and from developing to developed countries.

78. Furthermore, there is an exodus of skilled health workers from public health services to the private sector due to attractive pay and working conditions. Most of the public health services suffer from low pay, poor occupational health and safety conditions, lack of training and prospects for career advancement, poorly supplied medical facilities, an acute shortage of staff, and poor management and overall health system governance. The Inspector believes that the magnitude of the health worker shortage cannot be overstated and that it requires an urgent, sustained and coordinated response with a focus on long-term training plans supported by immediate and longer-term financing of human resources.

79. The implementation of the following recommendation is expected to enhance the effectiveness of UNAIDS at country level.

Recommendation 6

In order to enhance the effective implementation of universal access to antiretroviral therapy, the executive heads of the UNAIDS secretariat and the Cosponsors should:

(a) Assist the affected Member States in developing policies and procedures aimed at developing combined short and long-term human resource strategies for the purpose of improving conditions for current workers;

(b) Provide technical support to develop adequate training programmes for health workers;

(c) Undertake advocacy programmes to discourage migration of health workers to other countries.

Stigma and discrimination

80. Although HIV discrimination is illegal in most countries, yet it still exists. Ignorance about how HIV is transmitted as well as homophobia, racism and anti-immigration sentiment combine to make HIV an extremely stigmatized condition. People living with HIV can experience prejudice and discrimination at their place of work, in accessing health care, in the media and among friends and relatives. HIV prejudice can prevent people from testing for HIV or accessing health care for fear of discrimination, or being associated with risk behaviours, or if diagnosed HIV positive. This has serious consequences for people's health and can limit the effectiveness of treatment.[9] In other words, stigma and discrimination continue to be an obstacle in rolling out universal access to all PLHIV in need of ARVs. The Inspector was given to understand also that stigma and discrimination discourage people from seeking the information and services that will protect them from HIV infection or determine whether they are already carrying the virus. It impedes PLHIV from adopting safe behaviours and seeking access to ARVs.

81. Also alarming is the fact that discrimination against the most vulnerable and neglected groups: women, intravenous drug users, sex workers and men who have sex with men is widely prevalent. In addition, HIV-related human rights are not high on the agenda of some of the affected Member States and international donors. Challenging stigma and discrimination, therefore, should continue to be central to the work of UNAIDS, aimed at campaigning for better legal protection against HIV-related discrimination; challenging national policies that discriminate against people affected by HIV; and developing awareness campaigns and producing materials that change people's attitudes and behaviour. More resources and political commitment should also be mobilized to address problems associated with stigma, discrimination, gender and human rights. The integration of all aspects of prevention and treatment interventions into public health systems will contribute immensely in terms of redoubling international efforts towards achieving the goal of eradicating stigma and discrimination against the affected populations across the globe.

82. The implementation of the following recommendation is expected to enhance the effectiveness of UNAIDS at country level.

Recommendation 7

The executive heads of the UNAIDS secretariat and the Cosponsors should assist the affected Member States in developing policies and procedures aimed at addressing the problem of stigma and discrimination. They should also undertake public awareness programmes to advocate that people living with HIV enjoy the same legal rights as everyone else.

[9] *Stigma and Discrimination*, National Aids Trust, at www.nat.org.uk/HIV.

Universal access vis-à-vis prevention efforts

83. One of the major challenges for universal access is the continuance of focus and efforts on prevention activities. The Inspector is concerned that in the countries visited the scaling-up of ART had shifted focus onto treatment and considerably weakened prevention efforts. The challenges posed by universal access are formidable and this has absorbed the available scarce resources. As a result, many of the civil society partners that were traditionally involved in community mobilization and prevention, have shifted their focus to treatment support activities, resulting in greater reduction in efforts towards scaling up of prevention activities.

84. Furthermore, the major part of donor funding is earmarked for treatment and the affected Member States are not able to allocate a matching share of domestic funding to prevention efforts. As stated in paragraph 68 above, unless the current rate of six new infections for every person put on ART can be dramatically reduced in the years to come, the affected Member States will only move further away from universal access. The Inspector believes that in order to halt and reverse HIV/AIDS by 2015, both prevention and treatment should be enhanced simultaneously. Treatment can make prevention more effective, and effective prevention will ultimately make treatment much more feasible and affordable. UNAIDS should, therefore, strongly urge the affected Member States, in coordination with their donors, to take the necessary steps to re-emphasize both immediate and long-term strategies for enhancing HIV prevention, in synergy with the rapidly expanding ART programmes.

85. The implementation of the following recommendation is expected to enhance the effectiveness of UNAIDS at country level.

Recommendation 8

The executive heads of the UNAIDS secretariat and the Cosponsors should strongly encourage and assist the affected Member States, in coordination with their donors, to take the necessary steps to re-emphasize the need to devise both immediate and long-term strategies for enhancing HIV prevention in synergy with the rapidly expanding ART programmes.

Long-term sustainability

86. The financial resources needed for HIV/AIDS show an increasing trend due to the increase in the numbers of people living with HIV and the expansion in HIV/AIDS programmes to serve more of those in need. According to UNAIDS estimates[10] the financial resources available for HIV and AIDS fall far short of what is needed to scale up towards universal access. UNAIDS estimates that the amount needed for an expanded response in low and middle-income countries will be US$18.1 billion in 2007, US$ 22.1 billion in 2008 and US$ 30.2 billion in 2009. Against this, the money received, the existing pledges, commitments and trends indicate that the available funds are US$ 10 billion for 2007 and the annual resource gap will therefore be US$ 8.1 billion in 2007. UNAIDS estimates that to meet the goal of universal access by 2010, available financial resources for HIV must quadruple by 2010 compared to 2007 – up to US$ 42.2 billion and continue to rise to US$ 54

[10] UNAIDS report entitled *Financial Resources Required to Achieve Universal Access to HIV, Prevention, Treatment, Care and Support*, dated 26 September 2007.

billion by 2015. To achieve this huge requirement, existing domestic financing and international donor commitments must be fulfilled and new ones made, and innovative financing mechanisms should be devised and implemented in order to tap new sources of funding.

87. Furthermore, the health systems in developing countries have been severely underfunded for decades and need significant investment over the long term to improve and expand provision to meet the universal access target. The WHO Commission on Macroeconomics and Health estimated that an additional US$ 27 billion per annum in aid is needed to strengthen the capacity of health systems so that they can deliver basic health-care packages effectively. Meeting this target would require a fivefold increase in donor spending on health and does not include free access to ART for everyone in clinical need.

88. The challenge of ensuring adequate funding for HIV/AIDS is daunting. ART programmes are a life long requirement for HIV/AIDS patients. All stakeholders the Inspector met during his meetings were concerned about the sustainability of ART programmes and the future treatment costs for the increasing number of people who had started treatment with the help of the available funds. There is, therefore, an urgent need on the part of UNAIDS to strongly advocate and help to devise some sort of innovative financing mechanism that would ensure the long term sustainability of ART programmes in all the affected countries.

89. The implementation of the following recommendation is expected to enhance the effectiveness of UNAIDS at country level.

Recommendation 9

The executive heads of the UNAIDS secretariat and the Cosponsors should strongly encourage and assist the affected Member States, in devising innovative financing mechanisms, both at national and international levels, to ensure long-term sustainability of antiretroviral therapy programmes.

V. THE ROLE OF CIVIL SOCIETY

90. In the fight against HIV/AIDS, civil society organizations,[11] often in partnership with the United Nations, gained prominence in advocating the multisectoral problems of HIV/AIDS. With increased rates of infection and the reluctance of the affected Member States to get more involved in devising solutions to problems inflicted by HIV/AIDS, civil society partners have developed to fill the gap. With the reluctant support of the affected Member States, civil society has gained the recognition of the international donor community, which has sought to channel development aid through them. Since its establishment in 1996, UNAIDS has been actively promoting partnership with civil society in the fight against HIV/AIDS. UNAIDS was the first United Nations programme to have formal civil society representation, in a non-voting capacity in its governing body. The PCB has five members representing civil society. The World Bank's Multi-Country HIV/AIDS Programme for Africa used NGOs as implementing partners. The Global Fund to Fight AIDS, Tuberculosis, and Malaria requires country proposals to pass through country coordinating mechanisms (CCMs), which also involve the participation of civil society.

91. Civil society's role is pivotal in the implementation of the target 7 - to have, by 2015, halted and begun to reverse the spread of HIV/AIDS. They are involved in a wide spectrum of activities in creating awareness, providing proper counselling, promoting safe sex, care and treatment seeking for HIV/AIDS cases. Many civil society partners possess unique qualities and comparative advantages, which make them particularly wellsuited to dealing with HIV/AIDS-related issues. The Inspector recognizes that civil society partners are often not under the same political constraints as government programmes. They have greater flexibility and the capacity to accommodate changing programmes and public needs. Indeed, they can innovate and implement new initiatives more easily. They are not only adaptable, but also work closely with the people most affected by HIV and AIDS. They have succeeded in intervention programmes at grassroots level that are dependent on understanding local social, cultural and environmental contexts, and on mobilizing and ensuring the meaningful participation of local populations.

92. The Inspector notes that while civil society's contribution to the achievement of the target is potentially great, several obstacles do exist in terms of ensuring their effective participation. For instance, adequate funding remains a major problem. As a result, the Inspector noted that many national civil society partners in Uganda, Kenya and Tanzania were scaling down projects to match funding patterns and abandoning more ambitious projects. In addition, the reluctance of donors to fund non project-related or overhead expenses in terms of salaries, rents or research, further limits their ability.

93. The other factor is government antagonism towards involvement of national NGOs in AIDS programmes. This conflict between Governments and national NGOs emanates mainly from the perception of competition for funding. Often the funds that donors have chosen to donate to national NGOs for HIV/AIDS initiatives might have been provided to the Government in their absence. Because of these perceptions, certain government agencies are hesitant to involve national NGOs in AIDS response. Furthermore, the United Nations system organizations are often unfamiliar and uncomfortable in dealing with non-State actors. Despite recent changes, most United Nations staff still view their primary working relationship to be with Government. Most Member States are reluctant to have a United

[11] Civil society organizations include international and national NGOs, AIDS service organizations, groups of people living with HIV and AIDS, youth organizations, women's organizations, business, trade unions, professional and scientific organizations, sports organizations, religions and faith-based organizations.

capacity and the necessary financial and human resources to enable them to undertake similar AIDS awareness campaigns in their respective countries.

100. The implementation of the following recommendation is expected to enhance the effectiveness of DPI and its relationship with UNAIDS both at country and global levels in the fight against HIV/AIDS.

Recommendation 11

The Secretary-General should:

a) Urge the Department of Public Information (DPI) to enter into a memorandum of understanding with the UNAIDS secretariat, with the objective of identifying critical areas of cooperation and collaboration and with a view to ensuring effective dissemination of information on HIV/AIDS-related activities across the globe;

b) Urge DPI to assist in building the capacity of those countries that do not have the capacity and resources necessary to undertake effective AIDS awareness campaigns in their respective countries.

VII. THE WAY FORWARD

A. United Nations niche

101. If there is one thing that has greatly intrigued and inspired the Inspector in the course of his mission in all the countries visited, it is the unflinching commitment and steadfastness of resolve that have been demonstrated by the representatives of various United Nations system organizations in their common efforts towards achieving the target related to the fight against HIV and AIDS. As a matter of fact, all the UNAIDS country coordinators (UCCs) in the countries visited have demonstrated their readiness and willingness to work closely with their colleagues from other United Nations system organizations within the framework of various country teams groups in relation to HIV/AIDS activities. Importantly, their close cooperation and collaboration with the national authorities have continued to be instrumental in supporting national efforts and response in the fight against HIV/AIDS. The Inspector has also learned that in countries such as Brazil, India, South Africa, Botswana, Poland, Russia, etc, that have plenty of financial resources of their own devoted to the fight against the pandemic, the only thing that the authorities in such countries want to hear is excellent innovative ideas from the United Nations family that could assist them in making the fight against HIV/AIDS much more effective, efficient and sustainable in the long run.

102. In other words, despite the tremendous successes and achievements of the UNAIDS secretariat and the Cosponsors in terms of sensitizing global public awareness to the issues of infection and transmission of the disease, prevention, treatment, care and support, stigma and discrimination, it is nonetheless rather discouraging to realize that the prevalence rate of infection continues to rise in most risk groups across the globe. More and more infected people are on treatment and the prospects for finding an effective AIDS vaccine and/or cure lie mostly in the realm of wishful thinking.[13] As a result of this unfortunate situation, and as the response of Member States to HIV/AIDS is expected to remain active for the long haul, notwithstanding the high costs associated with it, it is the view of the Inspector that if the organizations of the United Nations system are to remain valid and relevant in the fight against HIV/AIDS they should focus attention more than anything else on devising excellent innovative ideas and new strategies as alternative and/or complementary means to ensuring an effective, sustainable long-term response to HIV/AIDS.

103. On the other hand, a good number of Member States from poor developing countries have continued to depend heavily on foreign bilateral donors as a reliable means of funding in support of a national response to HIV/AIDS. If unchecked, this will be an extremely dangerous trend in the long-term sustainability of the fight against HIV/AIDS. The United States Government PEPFAR, GFATM, the Bill & Melinda Gates Foundation and the William J. Clinton Foundation, along with a multitude of other international NGOs have increasingly become the major sources of funding in most of the poor developing countries for treatment, care and support programmes. In other words, without foreign donors, it is safe to assume that national efforts in the fight against HIV/AIDS in these countries will not be sustainable in the long run; it is even possible that such efforts may collapse altogether.

104. There is, therefore, an urgent need for the United Nations to undertake deliberate strategic measures to assist poor developing countries, that have limited financial resources of their own devoted to HIV/AIDS, to devise new strategies and innovative development

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[13] Sabin Russell, "Buffett's gift lifts hope for elusive AIDS vaccine", *San Francisco Chronicle* (28 June 2006).

financing mechanisms that would enable them to respond to HIV/AIDS in a much more coherent, independent and sustainable manner than is currently the case. These may include innovative ideas on how, for example, to build not only effective local health infrastructures but also develop local industries, franchises, and other profit centres that can sustain and thrive from increased health-related spending. The Inspector believes that such financing mechanisms could contribute immensely in assisting the affected countries to respond to their specific needs, such as increasing the supply and lowering the price of drugs without compromising their quality.

105. For instance, GFATM and the international drug purchase facility UNITAID, are excellent examples of the kind of innovative financing mechanisms put in place during this decade in response to the fight against HIV/AIDS and other diseases. By the same token, it would be an excellent idea if most poor developing countries could be provided with the necessary and timely assistance that would enable them to establish their own versions of UNITAID and/or GFATM that would guarantee them sustainable financing of large-scale HIV/AIDS-related programmes for treatment, care and support. There is no doubt that any success in assisting the poor developing countries to attain financial independence and long-term sustainability in the implementation of their programmes in the fight against HIV/AIDS will not only help to establish a genuine public health policy for AIDS and bring the international community closer to achieving the goal of universal access by 2010, but will also be another giant step and an A-plus for the continued validity and relevance of the United Nations system organizations.

106. While the international community, and more particularly the United Nations system organizations, seem to be increasingly optimistic about the future prospects for the global fight against the HIV/AIDS pandemic, after more than 100 meetings/interviews with representatives of Governments, NGOs, civil society and more importantly with various officials of the United Nations system organizations in the countries visited, the Inspector has unfortunately come to the conclusion that the world is currently losing the battle against HIV/AIDS. One has only to look at the available numbers and statistics to be alarmed by the scope and magnitude of the public health problem that the HIV/AIDS pandemic continues to pose to the international community; and how difficult it has been for the affected Member States, despite the massive financial and human resources that have been deployed since the early 1980s when the first HIV/AIDS case was reported.

107. While there is no doubt that some progress has been made in the fight against HIV/AIDS, as indicated earlier, the numbers tend to show that more people are currently being infected with HIV than are being treated. In other words, new infections are continuing to outpace the global effort to treat and educate patients.[14] Consequently, in the absence of the urgently needed cure and/or vaccine, the adverse effects of HIV/AIDS will continue to afflict a significant segment of the world population, and more particularly poor people in poor developing countries for many more years to come.

B. Urgent need for AIDS vaccine

108. It is a common belief that a preventative vaccine would be the best way to control the spread of HIV. More than two decades ago, some HIV/AIDS vaccine experts proclaimed that an AIDS vaccine was but two years away from testing. Regrettably however, it has turned out that the prospects for finding an effective vaccine, as indicated earlier, are still elusive. According to some reliable estimates, the global AIDS vaccine effort is funded at

[14] "World losing fight against Aids", BBC News Update, 23 July 2007.

US$ 700 million a year – much of it for research - but the collective wisdom is that US$ 1 to 1.2 billion annually is needed for vaccine research. While the Global HIV Vaccine Enterprise has been seeking proposals for grants totalling US$ 300 million over the next five years for AIDS vaccine work, AIDS vaccine experts concede that what is holding up the development of such a vaccine today is not money, but the level of understanding needed to make a breakthrough.

109. In other words, some experts contend that HIV remains a devilishly complex foe because there are fundamental scientific studies that need to be conducted, concepts addressed and problems solved in order to understand the molecular nature of HIV and its interaction with the human immune system. For example, early attempts to develop a vaccine against it failed because the virus can quickly mutate into a form that sidesteps antibodies raised against it.[15] Twenty-five years into the AIDS epidemic, scientists still do not understand precisely which immune responses are necessary to protect an individual from HIV infection – the so-called correlates of immunity.

110. The recent decision by the international drug company, Merck, to halt trials on an HIV vaccine after a 10-year effort trying to develop it, is no doubt, a sad day for the global effort in the fight against the HIV/AIDS pandemic. The Inspector has learned that Merck's international trial, famously known as STEP, which is sponsored by the International AIDS Vaccine Initiative (IAVI) and funded by the United States National Institute of Allergy and Infectious Diseases (NIAID) involved 3,000 HIV-negative volunteers from diverse backgrounds between the ages of 18 and 45. Initially, Merck's vaccine showed an ability to turn on the immune system, which gave many people optimism that it would work. Indeed, it was hoped that exposure to the genes would prompt an immune response in the body so that cells containing the HIV virus would be recognized and destroyed.[16] Based on an interim analysis, and after it was discovered that more and more volunteers who were given the vaccine became infected, an independent monitoring panel recommended in September 2007 discontinuing the vaccination of volunteers, because it was generally believed that the trial was not only not efficacious, but was also headed for failure.

111. Nevertheless, despite this temporary setback, the need for an AIDS vaccine is more compelling today than at any time in the history of the pandemic. The need for creation of more sites in developing countries where vaccine trials can be launched is, therefore, imperative. Such trials require willing and informed volunteers, political support from host nations and a medical infrastructure that can track outcomes for up to five years from vaccination. Most of the effort to develop and evaluate HIV vaccines is borne by the National Institute for Health (NIH), Centre for Disease Control (CDC) and Walter Reed Army Institute of Research (WRAIR) in the USA; and by the National Agency for HIV/AIDS Research (ANRS) in France, with strong help from IAVI in New York, the European Union, initiatives in WHO and UNAIDS, and the recent commitment of the Bill and Melinda Gates Foundation to the Global HIV Vaccine Enterprise.

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[15] See Sabin Russell, "Buffett's gift lifts hope for elusive AIDS vaccine", *San Francisco Chronicle* (28 June 2006).

[16] "Merck abandons HIV vaccine trials". BBC News Update, 21 September 2007.

112. Moreover, the HIV Vaccine Trials Network (HVTN) established by NIAID in 2000, with 25 clinical sites in four continents, represents a major resource for clinical HIV vaccine research.[17] The Inspector strongly believes that despite the setback, scientists and activists in the field of vaccine research should not be discouraged or disappointed. HIV, being a tough adversary, there will undoubtedly be more setbacks in the future but with increasing commitment and perseverance, a safe and reliable vaccine will ultimately be found. However, success will require the best science and a sustained commitment from the industry, academia, Governments and donors. In an effort to help end the AIDS pandemic, UNAIDS, and more particularly the WHO, in close collaboration with IAVI, should redouble their efforts to ensure the successful development of a safe and effective vaccine against HIV/AIDS by continuing to bring together all the relevant partners and mobilizing adequate financial resources for vaccine research.

[17] See WHO, Sexually Transmitted Diseases at www.who.int/vaccine_research/diseases/soa_std/en/index4.html

ANNEX

Overview of action to be taken by participating organizations on JIU recommendations

JIU/REP/2007/12

		Intended impact	United Nations, its funds and programmes												Specialized agencies and IAEA												
			United Nations*	UNCTAD	UNODC	UNEP	UN-HABITAT	UNHCR	UNRWA	UNDP	UNFPA	UNICEF	WFP	UNAIDS	ILO	FAO	UNESCO	ICAO	WHO	UPU	ITU	WMO	IMO	WIPO	UNIDO	UNWTO	IAEA
Report	For action		☒	☐	☒	☐	☐	☒	☐	☒	☒	☒	☒	☒	☒	☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐
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Recommendation 1														L													
Recommendation 2														L													
Recommendation 3					E			E		E	E	E	E	E	E		E		E								
Recommendation 4					E			E		E	E	E	E	E	E		E		E								
Recommendation 5					E			E		E	E	E	E	E	E		E		E								
Recommendation 6					E			E		E	E	E	E	E	E		E		E								
Recommendation 7					E			E		E	E	E	E	E	E		E		E								
Recommendation 8					E			E		E	E	E	E	E	E		E		E								
Recommendation 9					E			E		E	E	E	E	E	E		E		E								
Recommendation 10					E			E		E	E	E	E	E	E		E		E								
Recommendation 11			E																								

Legend: **L:** Recommendation for decision by legislative organ

E: Recommendation for action by executive head

☐: Recommendation does not require action by this organization

Intended impact: **a:** enhanced accountability **b:** dissemination of best practices **c:** enhanced coordination and cooperation **d:** enhanced controls and compliance **e:** enhanced effectiveness **f:** significant financial savings **g:** enhanced efficiency **o:** other

* Covers all entities listed in ST/SGB/2002/11 other than UNCTAD, UNODC, UNEP, UN-HABITAT, UNHCR, UNRWA.